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ATTACHMENT

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Fall 1987

### THE AIDS PANDEMIC CONTINUES

The incidence of the Acquired Immunodeficiency Syndrome (AIDS) continues to increase as more people with silent infection surface and progress into the ranks of the actively ill. In the United States those ranks double every 12 to 15 months.

The perception of a deficient immune system has been known as a medical entity for many years. For example, the children who must live in the sterile bubbles have congenitally deficient defense systems. AIDS, however, is the result of an acquired viral infection, first reported in the United States in 1981. The name of the AIDS virus is HIV, standing for Human Immunodeficiency Virus. Since 1981, 39,433 Americans with AIDS have been indexed by the Centers for Disease Control (CDC) and 23,165 of these have died as of 10 August 1987. Worldwide, 113 countries report 51,535 cases of AIDS as of June 1987. The U.S. Public Health Service estimates that documented cases will rise to 270,000 in four years. In the general population experts believe that there are roughly 1.5 million Americans infected with the virus, most of whom do not know that they are carriers. Hence, the feeling of health authorities that "the worst is yet to come," may prove to be correct. By 1991 the cost of AIDS care will surpass the medical costs of either breast cancer or lung cancer, and the time lost and money spent will exceed the present Medicaid budget by 100 percent, over \$66 billion dollars.

According to the World Health Organization (WHO), European sources have reported 3,858 cases from 23 countries through 1986. France reported the largest number (1,221), followed by the Federal

Republic of Germany (826), the United Kingdom (610), and Italy (523). Current estimates expect 30,000 cases in Europe by late 1988.

Between 2 and 5 million Africans are believed to be infected with HIV. Of those infected, a minimum of 400,000 can be expected to develop AIDS. Reporting from Africa has been difficult to assess, but the following countries have reported "over 100 cases": Ivory Coast, Central African Republic, Congo, Zaire, Uganda, Kenya, Tanzania, Zambia, Zimbabwe and Rwanda.

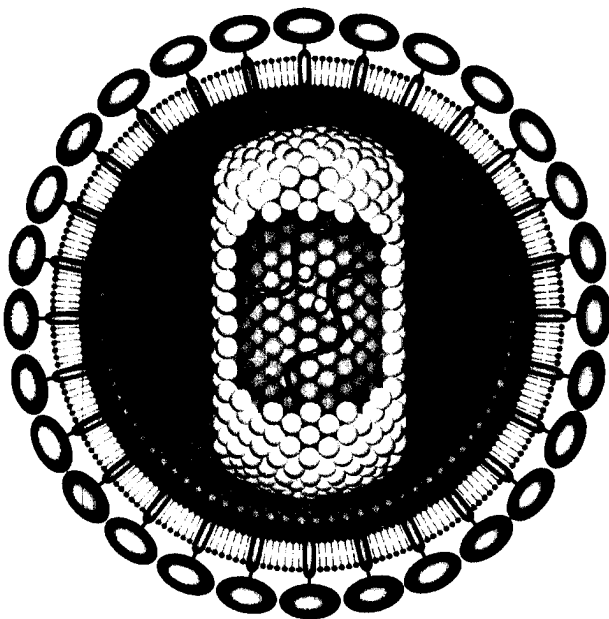
A small number of AIDS cases have surfaced in Asia with 38 in Japan, 9 in India, 6 in Thailand, and 4 in Hong Kong. Most of these have resulted from exposure to infected western blood products. There appears to be very little HIV positivity in the general population in Asia. Australia and New Zealand, with 470 and 37 cases respectively, follow the typical transmission patterns of other western countries. WHO suspects that worldwide there are between 5 and 10 million infected persons.

### A Virus and its Victims

AIDS continues to present in essentially the same populations as it did originally, namely homosexual and bisexual men (73 percent), heterosexual intravenous drug abusers (17 percent), Haitians living in the United States (4 percent), hemophiliacs (about 1 percent), and a disturbing but constant percentage of heterosexuals that cannot be classified as belonging to any high risk group, (1 to 3 percent). It is estimated that in the 1990's the climbing incidence of AIDS in heterosexuals will surpass the declining incidence in the homosexual population, a result of the latter altering their high risk sexual patterns and many already infected succumbing to the disease.

It should be borne in mind that AIDS probably originated as a heterosexual disease, and it was only by chance that the homosexual community bore the brunt of the initial impact. Current research into the origins of HIV points to a simian virus called STLV III, found in the Green Monkey of Central Africa. On the basis of the viruses' genetic similarities, it is presumed that STLV III mutated into the virus now called HIV and moved from a monkey host to a human host in the 1950's. It is this propensity for mutation that confounds the effort to develop a vaccine, for now a second HIV virus has been recovered from African AIDS victims, called HIV 2.

A relatively simple virus (Figure 1), HIV regrettably attacks two important cell-lines in the human, the white blood cells called T-helper cells, and a cell-line termed monocytes/macrophages. The T-helper cells are regulators of the immune system which defends us from infection. By the production of antibodies, by the generation of various chemical reactions, and by the mobilization of "killer" cells, our immune system normally destroys invading bacteria, fungi, parasites, and viruses. The defense plan for all this is recorded in the DNA of the genes of our white blood cells and in other cell lines. The HIV virus changes all of that, by being a "retrovirus." It enters the T-helper cells and, by working in a reverse manner to the normal scheme, re-programs the DNA of the T-cell with its own information, and becomes an integral, permanent part of the T-cell. Instead of programming for defense, the white cell is now set to produce more HIV virus when the cell is ultimately activated.



Persons thus infected may, or may not, experience an illness resembling "flu" or mononucleosis, about 3 weeks after the invasion. This early infected period is called Stage I (CDC classification). Since the virus is alive and active, these persons are infectious but, other than this mild illness, they probably appear perfectly well.

The hallmark of the next stage is the development of antibodies to HIV. An antibody is a protein produced by a different line of white blood cells called B-cells. While natural antibodies serve a defensive role in many infections, unfortunately they do not fight against HIV. The presence of the antibody does serve as a marker for HIV infection and is technically easier to detect than the virus itself. Within two weeks to six months from the time of infection, the HIV victim begins to produce antibodies that unsuccessfully attempt to defend him and which we detect by the ELISA test. He is termed HIV-Antibody positive and has entered Stage II. Regrettably, until one develops a detectable antibody, there is no simple method of screening a large number of people for infection. The number of HIV particles circulating early in the illness is relatively small, apparently less than we find in the early stages of other viral illnesses, such as hepatitis. ELISA only detects the presence of the antibody. It does not detect the actual presence or the concentration of the virus particle. Nevertheless, these patients are infectious, and it is presumed that the virus is invading the T-cells and beginning to take over the DNA of those cells.

During this 2 week to 6 month window between the initial invasion and the production of detectable antibody, an infected individual will have a negative HIV test. Therefore it is possible for a person in the early stages of infection, having a negative blood test, to transmit HIV if he or she donates blood or has unprotected sex. Until we can easily detect the virus particle, as we can do with Hepatitis B, we will theoretically be at risk from those donors with false negative tests. Blood banks attempt to circumvent this problem by also providing prospective donors with exclusion criteria which, if fulfilled, are a basis for declining donations. Those criteria define people at high risk of infection and are listed in the table.

Since it is apparently not in the virus' best interest to destroy its host immediately, it now begins a variable period of "incubation." The individual is generally without symptoms (asymptomatic) and may stay this way for many years. The presence of symptoms marks the development of the syndrome (a group of symptoms and signs which characterize a disease).

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### **Risk of HIV Infection and Exclusion Criteria for Blood Donation:**

Use of illegal drugs by needle

Known positive HIV blood test

Diagnosis of AIDS or AIDS-related complex

History of sexual contact of the following types:

- Contact with a person who has AIDS or AIDS-related complex
- Male homosexual contact since 1977
- Contact with natives of Haiti, Burundi, Kenya, Rwanda, Tanzania, Uganda or Zaire who have entered the U.S. since 1977
- Contact with people having a positive HIV blood test
- Contact with a hemophiliac
- Contact with male or female prostitutes

History of receiving a blood transfusion or having a sexual contact while in one of the foreign countries listed above.

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Presently it appears that 20 to 38% of the asymptomatic group will develop the full-blown illness within the 5 years following their initial infection. One research group reports that 50% will develop the syndrome in 7 years. Some experts suspect that all of those infected will eventually progress to some overt manifestation, possibly with a 100% mortality.

The incubation phase is associated with a period of virus production and slow infiltration of the host's immune and nervous systems. There is a variably progressive destruction of the T-helper cells and the nervous system cells. Apparently the HIV can infect the nervous system and produce neurologic disease, particularly dementia, without producing other symptoms characteristic of AIDS. As the T-cells decline in number, the body attempts to compensate by producing more, as it normally does. In some patients the lymph glands enlarge in an attempt to meet the demand. This generalized enlargement of the lymph nodes is termed "adenopathy." Recall that the French investigators originally named the virus the "Lymph-Adenopathy-associated Virus" (LAV) and the Americans, the "Human T-cell Lymphotropic Virus" (HTLV-III), meaning one that stimulated T-cell production. Both sides recently agreed on HIV as the common name.

Patients with adenopathy test positive for HIV antibody 90% of the time, and the actual virus can be recovered in 85.7% of these persons. By definition

they are asymptomatic, other than having enlarged lymph nodes, and are placed in their own category, Stage III.

Thus we have three groups of relatively healthy-looking, almost asymptomatic, infected individuals who may go 5 to 7 years or more before developing symptoms. Symptoms mean the syndrome—AIDS.

### **AIDS, The Overt Disease**

The events that trigger the progression from asymptomatic HIV infection to symptomatic AIDS, termed Stage IV, are most likely the following:

1. A second infection (a co-infection).
2. Pregnancy, which normally reduces the white cell population of the mother.
3. Stress situations which exhaust the immune system.

In the healthy individual the immune system compensates for these challenges, the balance is restored and the patient fights off the illness and recovers. Not so in the AIDS patient with a deficient immune system.

Stage IV is marked by an absolute measurable decrease in the number of T-helper cells and platelets, the presence of multiple co-infections and cancers. If one considers the numerous co-infections possible in Africa and Haiti, one can better understand the rapidity with which African patients progress to Stage IV.

Many of the co-infections seen in the United States are caused by fungi and parasites that the intact immune system can generally handle easily. In AIDS there is no longer a normally functioning immune system, and simple organisms such as the yeast *Candida* that causes "thrush" in infants' mouths, develops into a debilitating diarrhea and severe oral infection. An unusual form of tuberculosis frequently seizes the opportunity to infect the AIDS patient, hence the term "opportunistic infection." Other viruses, particularly herpes zoster (shingles virus), Epstein Barr (mononucleosis), and cytomegalovirus, have the ability to stimulate the HIV to proliferate, which accelerates the process of destroying T-helper cells. Organisms called *Cryptosporidia* and *Microsporidia* chronically infect the intestinal tracts of AIDS patients and probably play a role in the dramatic weight loss which occurs.

A parasite called *Pneumocystis carinii*, which seldom threatens a healthy person, is the cause of a pneumonia that has a 30 to 50 percent mortality in AIDS patients. It is the most common of the life-threatening opportunistic infections, and, although it may respond to treatment temporarily, it tends to recur. Complicating the treatment, AIDS patients more often develop severe allergies to the medication used against *P. carinii*. The list of other co-infections is extensive and now includes *Salmonella*, *Histoplasmosis*, *Toxoplasmosis*, pneumococcal pneumonia, hookworm, and numerous other organisms that normally inhabit our environment but seldom attack us successfully.

Stage IV is also associated with the development of cancers. Ordinarily, "killer" T cells and other defense mechanisms aid in the fight against malignant transformation of normal tissue, which is believed to occur in everyone from time to time. In the individual with AIDS, this protection is lost and cancers develop. One such growth is Kaposi's sarcoma. It was the increase in the incidence of this previously rare tumor, in male homosexuals in 1981, which alerted the medical community that something unusual was happening. Homosexual men with AIDS have a 46% incidence of Kaposi's sarcoma at their initial diagnosis, which suggests to some researchers that other factors are involved. They suspect that the cytomegalovirus, found concomitantly in 94% of male homosexuals and in 66% of intravenous drug users, is one of these enhancing factors. Despite some success in treating these tumors with interferon, radiation, and drugs, the overall survival of AIDS patients has not been improved. This is in contrast with Kaposi's sarcoma in patients who do not have AIDS and whose average survival time is 13 years with treatment.

Malignant changes in the lymph system (lymphoma) and Hodgkin's Disease are frequently reported, along with rectal cancer and cancer of the tongue. Ultimately the AIDS patient progresses to a terminal stage. With multiple systems under attack and despite maximum available treatment, there is very little that anyone can do to stem the tragic, inevitable demise. Presently about 50% of individuals with AIDS are predicted to die within 2 years of their diagnosis.

### Who Gets AIDS?

AIDS continues to occur in the same high-risk groups in which it was originally described. Perhaps it is of more interest to delineate *Who* does *Not* get AIDS!

AIDS does not appear to be spread through the air. You will not contract it on a crowded subway, although you might catch tuberculosis there. You will not get it from shaking hands with an AIDS victim, or eating food prepared by him. You will not get it from sharing cigarettes, unless a substantial amount of virus-containing saliva is exchanged. You will not get it from toilet seats, hair brushes, or sharing tools. A barber's razor or scissors cannot transmit HIV unless they are grossly contaminated and your skin is cut in the process. The virus is fragile by comparison to many bacteria, parasites and other viruses, such as Hepatitis A and B, which are able to exist in the soil and water.

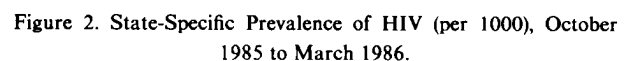
It has been estimated that it would take 2,800 bites by HIV-infected mosquitos to deliver a sufficient virus load to pose even a theoretical threat. In fact, there is no evidence that mosquitos are able to transmit living virus. As for transmission by other insects, especially African bedbugs, the CDC reports there is no evidence that the virus replicates in the bug or is excreted in the feces. The virus can be found in the bugs but it disappears in a few days, probably due to the digestive process of the bedbug.

The negative insect-vector conclusions are based on the observation that there are virtually no unexplained cases of AIDS in the 10 to 14 year old age group, a group commonly exposed to mosquitos and bugs. Of 26 cases of AIDS in this age group all contracted their disease from blood or blood-product transfusions or were assaulted by an AIDS carrier. In a later study of 62 children age 5-15, 61 fit into "established risk categories." In the remaining case the risk investigation by CDC was incomplete at the time of the report.

In the matter of blood transfusions, the risk in the United States is "close to but not quite zero." By carefully screening out high risk donors and by testing blood for HIV antibody, the Red Cross has done all that is technically feasible at present to reduce transfusion-induced AIDS. Since their HIV screening program was only initiated in the Spring of 1985, it is recommended that persons who received transfusions from 1978 to the Spring of 1985 be tested for HIV antibody. In the State of Virginia, 23 cases of AIDS have been possibly associated with transfusions of blood products. The average number of transfusions received was 20 for patients on whom suitable data was available. The median incubation period calculated from the last date of transfusion to the date of AIDS diagnosis, in 20 patients studied, was 37 months.

In 619 cases of persons living with an HIV-positive individual, but *not* having sex and not abusing IV drugs, there were no cases of AIDS. In over 2,500 incidents of accidental needle sticks involving health care workers in the AIDS setting, there were only 3 documented cases of HIV transmission. In sum, the evidence is overwhelming that, except for very specific risks, HIV infection is very difficult to acquire.

In the high prevalence areas shown in Figure 2, authorities are beginning to note male to female ratios approaching 1:1. This is similar to the ratio in Africa, where the mode of transmission is largely heterosexual. Since Africa is about 5 years ahead of the rest of the world in its epidemic, it is reasonable to infer that heterosexual transmission worldwide will produce similar ratios. In the United States it means relatively more females are being newly infected. (Figure 2)



In America 67% of all adult AIDS cases are found in non-Hispanic Whites. However, in the high prevalence cities, the highest positive rates are among Blacks, followed by Hispanics and then Whites. Along the same line, heterosexual IV drug users in New York test positive for HIV in 59% of the cases, while 100 miles away from New York City, addicts only show a 2% positive rate. Broad statements like, "Everyone who is sexually active is at risk," should be qualified to point out that the risk is not equally distributed.

Hemophiliac males who test positive for HIV because they have received contaminated blood products during the treatment of their condition appear to pass the virus to their heterosexual partners in a manner that reflects the state of their infection. Female partners test positive 10% of the time if their partner is asymptomatic, but 71% after their consort advances to Stage III.

Internationally the published incidence of HIV-infected prostitutes varies considerably with the country's reporting capability. In the United States 40% of the prostitutes tested on the East Coast were positive. In California the percentage was about half that of the East. In Germany the rate varies with locality and ranges up to 40%. Several U.S. soldiers have been infected and one family has been secondarily infected. Greece reports 60% of its prostitutes test positive, Haiti 80%, India 2.9%, Kenya 32%, and in a small sample in Rwanda, about 80%.

According to a recent CDC report, the census of women in the United States who have acquired their infection heterosexually has doubled since 1982. Reviewing 1819 female cases, which represented 7% of all AIDS cases in the United States, the proportion due to heterosexual contact was 26% in 1987 versus 12% in 1982. The percentage due to intravenous drugs, however, was 52%, which makes this the most common means of transmission for women.

A number of female AIDS patients appear to have no identifiable risk factor. In a recent article in the Journal of the American Medical Association, this matter was discussed. The consensus was that these women were not aware of their exposure to an infected bisexual male or a drug user. The paper advocates that women reduce their risk by reducing sexual contacts and insisting on the use of condoms during casual intercourse. Having sex with an infected intravenous drug user is calculated to double the risk of being infected.

Condoms are not 100% fool-proof but they are significantly better than no protection. In a Miami study of 45 infected adults, only 12 couples used condoms. Two of the 12 were already infected at the start of the study and of the other 10 user-couples, one partner became infected. Spermicides have been shown to kill the AIDS virus in the laboratory but their effectiveness in the body is unknown.

### What About Testing?

Beginning in February 1987, the Agency began routinely testing for HIV antibody in:

1. Applicants for employment
2. Employees and dependents over age 18 who have physical examinations for official purposes (PCS, Overseas TDY, TDY Standby, Return from Overseas).
3. Those recommended by a staff physician (persons who received transfusions or blood products in the period 1978 to the Spring of 1985, hemophiliacs, and selected other individuals).

The Agency testing program relies on two laboratory procedures: The Enzyme-Linked Immunosorbent Assay (ELISA) and the Western Blot. Both detect antibodies to HIV but they do so in different ways. Because ELISA is less labor-intensive it serves as the screening study. If a blood sample is ELISA-positive the test is run again on the same sample. If it persists positive it is tested by the Western Blot method. Should the Western Blot read positive, a second blood sample is drawn and the entire three-step procedure is repeated. After the first positive ELISA, any ELISA that reads negative is repeated by a research laboratory such as at Walter Reed Army Medical Center. Likewise, any Western Blot that is equivocal is repeated by a major center for AIDS research.

Like any laboratory test, there are false positive and false negative results. By doing two different procedures and repeating them with a new sample, the chances of a "false" report are minimized. Nevertheless, the implications of a "positive" test are potentially devastating, and for this reason every effort is made to insure the utmost accuracy of the report and protection of the patient's confidentiality.

Fundamental to the Agency's HIV testing program is an established protocol for individuals who have a confirmed positive test. Any such individual will be informed directly by an Agency physician, and the

information will remain medically confidential. Applicants testing positive will be counseled but disqualified from Agency employment. If an Agency employee or dependent is HIV-positive, comprehensive counseling and further medical evaluation will be made available. Depending upon the stage of HIV infection, overseas assignability would be limited as appropriate. OMS policy is to regard HIV infection or AIDS the same as any other illness and to expect that an employee will continue to work as long as he or she is able to do so.

Testing can also be obtained in the community as follows:

*Alexandria:* Venereal disease clinic, open weekly at 517 North Saint Asaph Street in Old Town. Call 838-4388. Appointment necessary, no charge.

*Arlington:* Venereal disease clinic, open twice weekly at 1810 N. Edison Street. Call 284-8055. No appointment necessary, no charge.

*The Arlington Hospital blood bank,* 1701 N. George Mason Drive. Open for regular business hours. Call 558-6888. Appointment preferred, \$25.00 charge.

*Fairfax County:* The county is offering the AIDS blood test at its venereal disease and general health clinics. No appointment is necessary, but hours vary. There is no charge. The clinics are at the following locations, four of which combine general health and venereal disease screening:

- Fairfax City, 3750 Old Lee Highway, 691-2161
- Falls Church, 7115 Leesburg Pike, 534-8343
- Herndon/Reston, 1760 Reston Ave., 435-4610
- Mount Vernon, 6301 Richmond Highway, 765-1000
- Springfield, 5700 Hanover Ave., 569-6704 or 1031

### **Treatment Prospects**

Two tracks are being followed by HIV researchers, a palliative or curative drug treatment and a preventive vaccine. Azidothymidine (AZT), a cancer drug from the 1960's, shows some promise by slowing down the process of virus reproduction in the host cell. Regrettably AZT also depresses normal bone marrow production leaving some patients with unacceptably low blood counts. Other drugs are under investigation but only AZT has thus far been approved by the FDA.

Vaccines against retroviruses that infect animals have been produced and may serve as models for human vaccines. Using a technique of genetic engineering called recombinancy, the HIV genes that code for the proteins in its outer covering (envelope) have been dissected out and "recombined" with the genes of the smallpox virus. A vaccine was then made from this recombinant organism and given to mice and monkeys. These animals promptly made antibodies to the smallpox virus and also the HIV envelope. When challenged with AIDS virus, the presence of these antibodies stimulated the experimental animals to a higher degree of immune reaction. Since the HIV has the ability to mutate frequently (change its chemical make-up), a single vaccine strain may not be adequate. Consider that every year influenza vaccine has to be changed to meet the new influenza strain predicted for the winter. HIV has the added ability of causing infected cells to fuse with healthy cells and to transfer genetic material and virus particles from cell to cell without being exposed to circulating antibody. "Killer" T cells must be stimulated by a vaccine to open up these infected cells so that the antibody can attack the virus. For reasons not understood, the antibody produced by humans to HIV has a protective effect that diminishes with time and, in the presence of co-infections, apparently offers no defense at all.

Many empirical therapeutic approaches have been tried, such as identical-twin bone marrow transplant, administration of recombinant alpha interferon, natural and recombinant interleukin-2, and plasmapheresis of white blood cells. While some of the elements of the syndrome have improved temporarily, e.g., remission of cutaneous Kaposi's sarcoma, there has been no overall improvement.

### **Prevent Infection - Save Lives**

AIDS is 100% preventable. Scientists who study the transmission of disease (epidemiologists) point out that the pattern of HIV dissemination has been well investigated, and the virus relies entirely on sexual contact, parenteral infusion, or on perinatal circumstances. Were it otherwise, the types of patients seen would be different.

While an AIDS vaccine or a disease cure is not yet a reality, preventive measures are very effective. An OMS message released worldwide in June 1987 gave the following specific warnings:

1. Do not participate in unprotected vaginal intercourse unless it is within a stable relationship, otherwise use condoms and spermicide.

2. Avoid any intercourse with high-risk individuals or individuals from high-risk areas of the world.

3. Do not accept any transfusion of blood or any blood product that has not been screened for AIDS.

4. Do not accept any treatment involving a needle or injection unless you are certain the facility uses sterile disposable needles.

5. Avoid unprotected anal intercourse.

6. Be aware that oral-genital contact carries a risk of transmission.

7. In a situation where a potential sex partner may be infected, assume they are. A test for HIV antibody may be negative because the partner has not yet developed the antibody. In fact, there are rare

infected individuals who are incapable of making the antibody at any time. Know your partner.

The task is each of ours to halt the spread of HIV infection and AIDS. The warnings are clear and must be widely disseminated. For more information, contact OMS, your local health department or your family doctor.

**THE MEDICAL NEWSLETTER**

Suggestions and comments about the *Newsletter* should be directed to [redacted] of the Clinical Activities Division, Office of Medical Services, extension [redacted]

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# Office of Current Production and Analytic Support

## CIA Operations Center

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News Bulletin The Washington Post, Page D15

Monday, 30 November 1987  
Item No. 1

**JACK ANDERSON and DALE VAN ATTA**

## CIA Faces the AIDS Epidemic

**T**he Central Intelligence Agency has finally decided that it has to deal with the reality of the worldwide epidemic of acquired immune deficiency syndrome. The agency has sent out urgent warnings to all its agents and has begun routine testing of applicants, employees and their families to identify carriers of the deadly virus.

Earlier this year, the CIA issued a special alert to its spies in 15 countries, warning them to be more careful about their sexual contacts—whether recreational or on the job—with individuals who might have the disease. The countries of highest risk were identified as Haiti, France, Italy, the United Kingdom, West Germany, the Central African Republic, Congo, Ivory Coast, Kenya, Rwanda, Tanzania, Uganda, Zaire, Zambia and Zimbabwe.

We've obtained an internal report by the CIA's Office of Medical Services, which reveals that the agency "began routinely testing" employees and job applicants last February. It has been using two laboratory procedures, both of which check for the presence of antibodies to the AIDS virus, which is easier than detecting the virus.

The first procedure is a blood test called ELISA, for enzyme-linked immunosorbent assay. If the test result and a retest are positive, the Western Blot procedure is then used. "Should the Western Blot read positive, a second blood sample is drawn and the entire three-step procedure is repeated," the internal CIA report states.

"Like any laboratory test, there are false positive and false negative results," the report adds. "By doing two different procedures and repeating them

with a new sample, the chances of a 'false' report are minimized. Nevertheless, the implications of a 'positive' test are potentially devastating, and for this reason every effort is made to insure the utmost accuracy of the report and protection of the patient's confidentiality."

The spy agency's medical officers are testing three specific groups, according to the internal report:

"1. Applicants for employment.

"2. Employees and dependents over age 18 who have physical examinations for official purposes [such as posting abroad].

"3. Those recommended by a staff physician—[such as] persons who received transfusions of blood products in the period 1978 to the spring of 1985, hemophiliacs and selected other individuals."

The CIA has established a "protocol," or set of administrative courtesies that are extended to individuals "who have a confirmed positive test" to the AIDS virus, now known as HIV, for human immunodeficiency virus.

"Any such individual will be be informed directly by an agency physician, and the information will remain medically confidential," the report states, adding:

"Applicants testing positive will be counseled but disqualified from agency employment. If an agency employee or dependent is HIV-positive, comprehensive counseling and further medical evaluation will be made available. Depending upon the state of HIV infection, overseas assignability would be limited as appropriate."

THE WASHINGTON POST

WEDNESDAY, DECEMBER 2, 1987 E17

JACK ANDERSON and DALE VAN ATTA

## James Bond in the Age of AIDS

**P**illow talk can be expensive; it can cost you your life, the CIA has warned its secret agents around the world. The danger, of course, is AIDS.

The problem is that, unlike officials of other, less devious agencies, the CIA brass hats can't take the straight-arrow approach and urge their spies: "Just say no." The CIA is well aware that an undercover agent is sometimes exactly that, extracting information from susceptible, seducible targets who get carried away in the passion of the moment.

Even the KGB's notorious Delilahs must be growing a little nervous these days as the AIDS epidemic spreads inexorably throughout areas of East-West confrontation.

Faced with this mission-versus-medicine dilemma, the CIA's Office of Medical Services has come down on the side of protection.

"AIDS is 100 percent preventable," secret agents and other employees were assured in a bulletin issued in June. "Scientists who study the transmission of disease point out that the pattern of HIV (human immunodeficiency virus, the current name for the virus) dissemination has been well investigated, and the virus relies entirely on sexual contact, parenteral infusion or perinatal circumstances. Were it otherwise, the types of patients seen would be different."

So, the CIA medical bulletin explained, "while an AIDS vaccine or a disease cure is not yet a reality, preventive measures are very effective."

The bulletin offered seven precautions agents can adopt.

The first rule: "Do not participate in unprotected vaginal intercourse unless it is within a stable relationship; otherwise use condoms and spermicide." But this could easily rob the boudoir opportunity of the very spontaneity that has disarmed the quarry.

Second: "Avoid any intercourse with high-risk individuals or individuals from high-risk areas of the world." Following this sensible advice would place Africa and most of Europe off limits, as well as rule out gay men and intravenous drug users.

Third: "Do not accept any transfusion of blood or any blood product that has not been screened for AIDS." That's fine if the agent needs a pint of blood in Switzerland, but not in a Third World clinic where doctors have neither the equipment nor know-how to test for AIDS antibodies.

Fourth: "Do not accept any treatment involving a needle or injection unless you are certain the facility uses sterile disposable needles." Again, this is a bit unrealistic in many parts of the world.

Fifth ("Avoid unprotected anal intercourse") and sixth ("Be aware that oral-genital contact carries a risk of transmission") offer no special obstacles to the clever spy, while rule No. 7 is merely common sense: "In a situation where a potential sex partner may be infected, assume they are."

In short, the CIA bulletin warns: "Know your partner."

In the espionage game, the idea is to get to know your target well. But asking a potential paramour to take a test for the AIDS virus may not be an agent's most productive followup to "What's your sign?"

BROOM HILDA RUSSELL MYERS

